

SYNTHESIS OF FINDINGS

Substance Abuse Child Welfare Waiver Demonstrations

September 2005

U.S. Department of Health and Human Services
Administration for Children and Families
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This report is based on evaluation reports submitted by States that received title IV-E waivers to implement assisted guardianship demonstration projects: Delaware, Illinois, Maryland, and New Hampshire. Any conclusions noted in this report reflect the JBA project team's interpretations of the States' findings and do not necessarily reflect the viewpoints of the participating States or the Federal Government.

In addition to reviewing and synthesizing information from States' evaluations of their title IV-E waiver demonstrations, the JBA project team provides ongoing technical assistance to the States regarding the design and implementation of their evaluations and advises the Children's Bureau on evaluation issues related to the waivers. For further information on technical assistance, contact the Federal Project Officer at the following address:

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Synthesis of Findings from the State Substance Abuse Title IV-E Waiver Demonstration Projects Executive Summary

Since 1996, four States have implemented substance abuse waiver demonstrations: Delaware, New Hampshire, Illinois, and Maryland. Three States - Delaware, Maryland, and New Hampshire - focused on the early identification of parents with substance use disorders and service referrals, linking families to existing treatment resources and supportive services to

encourage caregivers to enter treatment and prevent out-of-home placement. Illinois has emphasized the recovery of caregivers who are not yet in treatment but whose children have already been removed from the home, using intensive case management and supportive services to improve treatment participation and retention rates, to facilitate reunification of parents with their children, and to increase the timeliness of decisions regarding other permanency options.

All States conducting substance abuse waiver demonstrations were required to conduct rigorous program evaluations with outcome and process components. Three States - Maryland, Illinois, and New Hampshire - employed random assignment designs for their outcome evaluations. Delaware used a comparison group design to examine differences in outcomes among clients in child protection units with access to enhanced substance abuse case management services compared with outcomes for clients in matched units without access to a substance abuse case manager.

Major findings and lessons learned from the demonstrations are summarized below. In interpreting the findings of these projects, it is important to note that with the exception of Illinois, most States had small sample sizes and/or encountered other problems in implementing their evaluations that placed caveats on the interpretation of their findings. Furthermore, because considerable differences in size, population characteristics, levels of urbanicity, and child welfare laws and policies, caution should be exercised in making comparisons across States regarding the effectiveness of their substance abuse demonstrations in improving child welfare outcomes.

Major Process Findings

- All four States faced serious problems with referrals and enrollments into their demonstrations. Among other implementation problems, very limited enrollment led Maryland to terminate its substance abuse demonstration early. Over time, Illinois was able to bring its enrollment numbers up to nearly expected levels.
- Illinois' demonstration experienced the greatest success in connecting caregivers to treatment services, with approximately 73 percent of parents assigned to the experimental group participating in treatment at some point in time, compared with 50 percent of parents in the control group, a statistically significant difference. Other States faced several implementation obstacles that limited clients' timely access to treatment.
- Among the States, only Delaware and Illinois collected specific data on the number of enrolled caregivers who remained in or successfully completed substance abuse treatment. Illinois reported modest improvements in substance abuse treatment initiation and retention; as of June 2004, 59 percent of active clients in the experimental group had either completed or were actively engaged in treatment. Delaware experienced more difficulties retaining clients in treatment; by the end of the State's waiver demonstration, only 24 percent of closed experimental group cases were actively engaged in or had completed treatment.
- Other implementation challenges reported by the States included inadequate worker training and education, staff turnover, and differences in the management styles and professional philosophies of child welfare workers and substance abuse counselors.

Major Outcome Findings

Overall, outcomes related to permanency and reunification were more difficult to affect in all States than outcomes related to treatment access, engagement, and retention:

- **Foster Care Placement Rates:** Delaware and New Hampshire studied the effects of their substance abuse demonstrations on foster care placement rates, defined as the proportion of in-home children enrolled in the demonstration who later entered out-of-home placement. Neither State found conclusive evidence that access to enhanced substance abuse services reduced rates of entry into foster care.
- **Placement Stability:** Illinois and New Hampshire assessed the effects of their demonstrations on placement stability, defined as the average number of times a child in foster care changes placement settings. To date, neither State has found evidence that access to enhanced substance abuse services improves placement stability.
- **Placement Duration:** Three States - Delaware, Illinois, and New Hampshire - studied the effects of their demonstrations on the duration of out-of-home placements. Delaware and Illinois demonstrated positive effects of their demonstrations on length of time in foster care placement. In particular, findings from Illinois suggest that children in families with access to intensive substance abuse services spend considerably less time in foster care. According to the State's latest progress report, children in the experimental group who returned home spent an average of 421 days in out-of-home care compared with 563 days for control group children, a statistically significant difference of 142 days.
- **Permanency Rates:** Illinois and New Hampshire examined the effects of their substance abuse demonstrations on permanency, defined as exits from foster care to reunification, guardianship, or adoption. Neither State reported significant effects of its demonstration on reunification or other permanency outcomes.
- **Maltreatment Recurrence:** Illinois and New Hampshire evaluated the effects of their substance abuse waiver demonstrations on maltreatment recurrence. The latest findings from Illinois indicate that families with access to enhanced demonstration services may experience less subsequent maltreatment, with a smaller, statistically significant proportion of experimental group caregivers having a repeat maltreatment allegation compared with control group caregivers. To date, New Hampshire has uncovered no effect of its waiver demonstration on subsequent maltreatment referrals.
- **Child and Family Well-Being:** New Hampshire has reported some initial positive well-being findings, including declines in problem child behaviors, reduced public assistance participation, increased parental employment, and increased enrollment in education programs. While many of these findings lack statistical significance, the pattern of somewhat improved outcomes across a number of domains suggests a positive trend for families receiving enhanced demonstration services.

Lessons Learned from the Substance Abuse Waiver Demonstrations

- To maximize referral rates, States must examine their assumptions regarding the identification of substance use disorders in their child welfare populations and carefully define the target populations for their demonstrations.
- Child welfare staff need early and ongoing training regarding substance abuse waiver demonstrations.

- Front-line child welfare staff also need better training and tools to identify and assess substance use disorders. To have an impact on families, improved identification must be accompanied by access to adequate and appropriate substance abuse treatment resources to which clients can be referred following identification of a substance use disorder.
- Successful child welfare - substance abuse collaborations require careful service coordination, strong managerial support, and consistent communication between child welfare staff and substance abuse professionals.
- States need reliable information tracking systems to promote the coordination of case management services and to improve the quality of evaluation data.
- To ensure cost neutrality, States must carefully define the eligibility criteria for their substance abuse waiver demonstrations.

In summary, all four waiver States experienced implementation problems, especially in recruiting caregivers to participate in their substance abuse demonstrations. However, the available evaluation findings suggest that intensive, proactive case management can improve access to treatment services and may have a modest positive impact on treatment retention and completion rates. Overall, the States' outcome evaluations uncovered no strong positive effects of the substance abuse demonstrations on foster care placement rates, placement stability, reunification rates, or permanency rates. Some evidence - particularly from Illinois - suggests that a substance abuse demonstration may reduce the duration of foster care placements and lower the risk of maltreatment recurrence. Other States considering the development of new interventions for the families of caregivers with substance use disorders are encouraged to study the lessons learned from these early demonstrations.

¹Due in part to the fact that their target populations included families with children who had not yet been placed in foster care, two States (Delaware and New Hampshire) experienced more difficulty achieving cost neutrality. In other words, the cost of serving families in their experimental groups was not able to be offset by decreases in foster care costs.

History and Legislative Context for Waivers

Public Law 103-432, authorized by Congress in 1994, introduced the concept of Federal waivers to child welfare programs. Conceived as a strategy for generating new knowledge about innovative and effective child welfare practices, waivers grant States flexibility in the use of Federal funds for alternative services and supports that promote safety and permanency for children in the child protection and foster care systems. The 1994 law authorized the Department of Health and Human Services to approve a total of ten child welfare waiver demonstration projects. The Adoption and Safe Families Act (ASFA) of 1997 extended and expanded the authority to use waivers for child welfare programs, authorizing the Secretary of Health and Human Services to approve up to ten new demonstration projects each year. Through the waivers, States may spend Federal funds in a manner not normally allowed under current Federal laws and regulations in support of innovative child welfare practices. Knowledge gained through these waivers provides a valuable source of information that can be used to inform changes in

policy and practice aimed at improving service delivery and enhancing the achievement of national child welfare priorities.

Federal child welfare waivers primarily affect the use of funds under title IV-E of the Social Security Act, which applies to payments for foster care. Available on an unlimited entitlement basis, title IV-E reimburses States for a portion of foster care maintenance expenses paid on behalf of eligible children and for related administrative costs. Among the requirements for eligibility is that children be removed from a family that would have qualified for the former AFDC grant under guidelines in effect in July 1996. Through the child welfare waiver legislation, States may apply to use title IV-E funds for supports and services other than foster care maintenance payments that protect children from abuse and neglect, preserve families, and promote permanency. Under a waiver, States may also expend Title IV-E funds on non-IV-E eligible children. When implementing a waiver project, States must remain in compliance with the following provisions of title IV-E:

- All requirements relating to the conduct of periodic foster care reviews;
- Requirements specifying safeguards for children during out-of-home placement;
- Required permanency hearings for children in State custody; and
- Requirements governing information to be included in a foster child's case plan.

The Department of Health and Human Services typically approves child welfare waivers for up to five years, although at the discretion of the Secretary they may be extended beyond five years. In addition to the provisions described above, waiver demonstrations must remain cost-neutral to the Federal government (i.e., States cannot receive more in Federal reimbursement than the State would have received in the absence of the demonstration) and they must undergo rigorous program evaluation to determine their efficacy. Since 1996, 17 States have implemented 25 child welfare waiver demonstration components through 20 title IV-E agreements. Some States have multiple waiver agreements, and some waiver agreements have multiple components. These projects examine innovative child welfare service strategies in several areas, including:

- Assisted guardianship/kinship care;
- Capped IV-E allocations and flexible funding to local agencies;
- Managed care payment systems;
- Services for caregivers with substance use disorders;
- Intensive service options;
- Enhanced training for child welfare staff;
- Adoption services; and
- Tribal administration of IV-E funds.

This synthesis report focuses specifically on the experiences and evaluation findings of the four States that have implemented substance abuse waiver demonstrations.

Growth of Interest in Assisted Guardianship Waivers

Over the last decade, a compelling body of evidence has grown that illustrates the major role of parental substance use disorders in many cases of child maltreatment, child welfare involvement,

and foster care placement. Most studies report that between one-third and two-thirds of substantiated child abuse and neglect reports involve substance abuse (U.S. Department of Health and Human Services, 1999). A brief review of recent national and state-level studies echoes this finding on the prevalence of substance use disorders in child welfare populations:

- A 1994 U.S. General Accounting Office report estimated that the number of cases in which parental drug abuse was the reason children entered foster care rose from 52 percent in 1986 to 78 percent in 1991 in Los Angeles, New York, and Philadelphia (GAO, 1994).
- According to a review of national estimates by Young, Gardner, and Dennis (1998), of the nearly one million children with a substantiated report of abuse and neglect in 1995, at least 50 percent had parents with substance use disorders.
- Data compiled by the State of Illinois in 1995 estimated that the percentage of children in foster care who were reunified with their families dropped significantly between 1990 and 1995 due to "epidemic levels of parental drug abuse" (Illinois Department of Children and Family Services, 1995).
- A 1998 study by the National Center on Addiction and Substance Abuse (CASA) revealed that over three-fourths of surveyed professionals (81.6 percent) identified alcohol in conjunction with other drugs as major contributors to child abuse and neglect (Reid, 1999).
- A 1998 study of Massachusetts' child welfare system estimated that between 70 and 80 percent of all child welfare referrals in that State involve some form of substance abuse (Institute for Health Recovery, 1998).

Children's safety and well-being are compromised in multiple ways when their parents abuse or are dependent on drugs or alcohol. Parents' inability to engage in appropriate parenting practices results in their children being deprived of basic nurturing activities and experiences. Parental abuse or dependence on one or more substances may prevent them from being emotionally or physically available to their children, rendering them more susceptible to emotional or physical trauma. Poor parental decisions regarding supervision are likely to place children at greater risk of physical harm. The cost of a parent's drug abuse diverts financial resources from providing for the basic physical needs of children, such as food and safe housing. Parental substance use disorders can, in some instances, lead to increased exposure to physical or sexual abuse. Finally, substance abuse combined with abusive parental behaviors can foster intergenerational patterns of substance use disorders and child maltreatment.

The stresses placed on child welfare systems by parental substance use disorders underscore the need for new or strengthened relationships with other agencies to facilitate the effective provision of treatment services. The breadth and depth of parental substance use problems, accompanied by the need to build or strengthen cross-organizational relationships, places considerable pressure on public child welfare agencies. However, many child welfare agencies struggle with identifying the best strategies for addressing the problems of substance-abusing caregivers. Some of the most serious challenges facing child welfare agency staff include insufficient expertise and training in identifying and addressing substance use disorders and a lack of available treatment resources, especially inpatient facilities for women and facilities that will accept women with their children.

The use of the title IV-E waiver demonstrations to implement substance abuse projects reflects a growing national realization that the substance abuse issues of parents must be addressed to decrease the incidence of out-of-home placement, reduce lengths of stay of children in out-of-home placement, and reduce the costs associated with foster care. These demonstrations have provided States with the means to institute reforms and explore the extent to which child welfare systems can more effectively address safety, permanency, and well-being for children in families with substance-abusing parents.

Overview of the Substance Abuse Waiver Demonstrations

Since 1996, four States have implemented substance abuse waiver demonstrations: Delaware, New Hampshire, Illinois, and Maryland. Findings from Delaware, which completed its five-year demonstration project in December 2002, are summarized in this paper from its March 2002 final report. Findings from New Hampshire, which began its effort in 1999 and continues under a short-term waiver extension, are based on its September 2003 interim report and a March 2004 progress report. Illinois, which started its initiative in April 2000, described project results in a May 2003 interim report, a June 2004 progress report, and a November 2004 progress report. Maryland, which began implementation in October 2001, terminated its demonstration early in December 2002 because of various implementation problems. These implementation barriers are summarized in its semi-annual report covering April 2002 through September 2002. Because of its decision to terminate the waiver early, Maryland obtained no data on the outcomes of its demonstration.

Key Characteristics of Assisted Guardianship Demonstration Projects

States implementing substance abuse waiver demonstrations must meet the requirements and limitations applicable to all waiver demonstrations, e.g., by providing all procedural and safety protections for children in foster care, conducting a rigorous evaluation, and maintaining cost neutrality. Beyond these core requirements, States have had great latitude in developing interventions that address the needs of children and their parents with substance use disorders. As Table 1 illustrates, the States vary considerably in terms of their target populations, organizational characteristics, and service delivery models. Given these substantial differences in program features, readers should exercise caution in comparing evaluation findings across States that implemented substance abuse waiver demonstrations.

Table 1
Summary of State Substance Abuse Waiver Demonstrations

State	Program Features	Target Population	Geographic Scope	Child's IV-E Status	Avg. Length of Service
Delaware	<ul style="list-style-type: none"> Implemented 7/1/96. Substance abuse counselors from 	Children in out-of-home care or likely to enter out-	Implemented statewide.	Both IV-E eligible and	8 months for foster case cases;

	<p>private agencies co-located with CPS staff to identify families to link to treatment and other services.</p> <ul style="list-style-type: none"> • Substance abuse counselors accompanied CPS workers on initial visits. • Substance abuse counselors arranged for substance abuse treatment and provided case management services. 	<p>of-home care due to parental substance use disorders.</p>		<p>non-IV-E eligible.</p>	<p>9 months for non-foster care cases.</p>
<p>Illinois</p>	<ul style="list-style-type: none"> • Implemented 4/28/00. • Parents in substance-affected families are referred to Juvenile Court Assessment Program (JCAP) at time of Temporary Custody hearing or at any time within 90 days of hearing. • JCAP staff conducts substance abuse assessment and refers caregivers for treatment if indicated. • Experimental group participants receive services from a Recovery Coach, who provides intensive support to 	<p>Custodial parents with a substance use disorder who have a child in out-of-home care; includes custodial parents who deliver drug-exposed infants.</p>	<p>Implemented in Cook County, IL.</p>	<p>Both IV-E eligible and non-IV-E eligible.</p>	<p>Reunification cases: Exp. group =14 months; Control group =19 months.</p> <p>Adoption cases: Exp. group = 37 months; Control group = 38 months.</p>

	families during and after treatment to prevent relapse and facilitate reunification.				
Maryland	<ul style="list-style-type: none"> Implemented 10/1/01. Family Support Services Teams (FSST) comprised of chemical addiction counselors, local child welfare agency staff, private contracted treatment providers, parent aides, and mentors. Three treatment options offered: (1) inpatient treatment for parents and their children; (2) intermediate care; and (3) intensive outpatient treatment. Services included: (1) case management; (2) individual, group, and family therapy; (3) housing, employment, child care, and transportation assistance; (4) health care and family planning; and (5) parenting skills training. 	Mothers or other female primary caregivers with a child in out-of-home care or at risk of placement due to parental substance use disorders.	Implemented in Baltimore City and Prince George's and Baltimore Counties.	Both IV-E eligible and non-IV-E eligible.	Not reported
New	<ul style="list-style-type: none"> Implemented 	Families	Implemented	Both	Not reported

Hampshire	11/15/99. <ul style="list-style-type: none"> • Licensed Alcohol and Drug Abuse Counselors (LADCs) work with CPS staff to identify parents who abuse alcohol and/or other drugs. • LADCs conduct initial drug and alcohol assessment. • As appropriate, substance abuse specialists refer parents to counseling and treatment, assist with case planning, link children and families to supportive resources, and provide direct outpatient treatment. 	involved in CPS with caregiver substance abuse as a major referral reason.	in 2 district CPS offices (Nashua & Manchester).	IV-E eligible and non-IV-E eligible.	
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Target Populations

Delaware and Maryland included families with children in foster care as well as those with children at risk of placement in their projects' target populations. Families in these States enrolled in the waiver demonstration following maltreatment assessment and CPS case opening. Like Delaware and Maryland, New Hampshire included families with children either at risk of placement or already in foster care, but had a somewhat broader definition of its target population in that families entered the demonstration immediately at CPS intake rather than after a maltreatment investigation and CPS case opening. Although referrals for substance abuse services could occur at any time, these three States expected case managers to assess the need for substance abuse services during their earliest meetings with families in an effort to prevent placement or facilitate earlier reunification. In contrast, Illinois has limited its substance abuse demonstration to parents with a child already in out-of-home placement and focused on increasing reunification rates and reducing lengths of stay in foster care. In Illinois, any caregiver who has lost custody of a child due to probable alcohol and drug abuse, including but not limited to post-partum women with a substance-exposed infant, is eligible for the demonstration project

as long as s/he is assessed within 90 days of the temporary custody hearing. All four States included both IV-E eligible and non-IV-E eligible children in their target populations.

Geographic Scope

The four demonstrations varied considerably in terms of their geographic scope. Delaware, a small state with only three counties, operated its demonstration statewide, whereas the other States limited their projects to one or two counties or municipalities.

Public-Private Partnerships

Another key difference among the States' demonstrations involved their use of public-private partnerships to provide substance abuse services. In New Hampshire, all principal service providers, including the substance abuse counselors, are public agency employees. In contrast, the other three demonstrations incorporated some degree of collaboration between public child welfare departments and privately contracted service providers. Illinois' Department of Children and Family Services contracted with a private case management firm to provide intensive case management services to parents with children in foster care referred for chemical dependency treatment. Maryland's demonstration centered on collaborative "Family Support Service Teams" consisting of substance abuse counselors, former substance abusers in recovery serving as mentors, parent aides, and privately contracted treatment providers. In Delaware, substance abuse counselors were employed by a contracted substance abuse treatment agency but in practice functioned like public employees by working on-site at county child welfare offices and by complying with Delaware Division of Family Services policies and procedures.

Service Delivery Models

Major differences exist in the service delivery models and service philosophies adopted by the States for their waiver demonstrations. Three States - Delaware, Maryland, and New Hampshire - have focused on the early identification of parents with substance use disorders and service referrals. These referrals were designed to link families to existing treatment resources and supportive services in the community in order to encourage caregivers to enter treatment and to prevent out-of-home placement. In contrast, Illinois has emphasized the recovery of caregivers who are not yet in treatment but whose children have already been removed from the home, using intensive case management and supportive services to improve treatment participation and retention rates, to facilitate reunification of parents with their children, and to increase the timeliness of decisions regarding other permanency options. Core features of each State's service delivery model are described in more detail below.

Delaware

Delaware's project essentially operated as a referral program, in which privately contracted substance abuse counselors were co-located with child protection case managers in county CPS offices to engage in joint case planning and decision-making. The State established one such "treatment unit" with a co-located substance abuse counselor in each of its three counties. The

primary responsibilities of the substance abuse counselor included linking clients to substance abuse treatment and providing support services to clients while they awaited treatment entry.

New Hampshire

Through New Hampshire's Project First Step waiver demonstration, licensed alcohol and drug abuse counselors (LADCs) work with child protection workers in an advisory and supportive capacity, using their clinical skills to provide training, assessment, treatment, and case management services. LADCs conduct an initial drug and alcohol assessment concurrently with CPS' maltreatment investigation. Each LADC is involved proactively from the outset in the risk and safety assessment to facilitate better decisions regarding child safety and possible out-of-home placement. Depending on a parent's level of cooperation, LADCs may provide direct outpatient treatment or procure treatment services on the parent's behalf, thereby improving the timeliness of access to substance abuse treatment services and increasing the potential for positive treatment outcomes. LADCs have the option to continue working directly with caregivers for an additional two months following completion of the maltreatment assessment or child protection case opening.

New Hampshire gave wide latitude to its two participating CPS district offices in which the demonstration was implemented, resulting in the establishment of two markedly different staffing arrangements. The Nashua district office chose to maintain its existing staffing structure, in which multiple supervisors oversee separate teams of caseworkers that provide services to families participating in the waiver demonstration. Consistent with the demonstration's service model, the Manchester district office designated one CPS supervisor to oversee all staff involved in waiver-related service delivery. The State expected that these differences in implementation might influence programmatic outcomes.

Illinois

Illinois' demonstration incorporates a proactive, intensive service philosophy. Its service model centers on the use of privately contracted case management specialists known as "Recovery Coaches" who directly engage families throughout the treatment process and provide needed post-treatment support. The Recovery Coach works with the parent, the child welfare caseworker, and the substance abuse treatment provider to remove barriers to treatment, engage the parent in treatment, provide outreach to re-engage the parent if necessary, and offer ongoing support to the parent and family throughout the duration of the child welfare case. As mentioned above, the Illinois model differs from those of other States in that it focuses on treatment retention and recovery for caregivers referred to, but not yet enrolled, in treatment and with a child already in out-of-home placement.

Maryland

Maryland planned to implement the most collaborative case management model among the four States, in which privately contracted chemical addiction counselors would work with child welfare case managers, parent aides, and volunteer mentors in "Family Support Services Teams" (FSSTs) to assess the needs of family members and determine appropriate treatment options.

Maryland's demonstration differed from other State demonstrations in that participating caregivers could be assigned to one of three pre-determined treatment modalities: (1) inpatient care for women and their children, (2) intermediate care (28-day residential care), and (3) intensive outpatient treatment. The FSST's chemical addiction counselor was authorized to provide interim treatment services until the caregiver entered treatment.

Program Intake and Substance Abuse Assessment

States with substance abuse waivers adopted widely varying approaches to enrolling families into their demonstrations and to assessing the presence and severity of substance use disorders. Table 2 summarizes key differences among the States in their intake and substance abuse assessment processes. As with the differences in target populations and service models discussed above, these distinct approaches to program intake and assessment render direct comparisons of the waiver demonstrations more difficult and reiterate the need for caution in interpreting evaluation findings across the States.

Table 2
Enrollment and Assessment Processes in States
With Substance Abuse Waivers

State	Timing of Enrollment into the Demonstration (assignment to experimental or comparison/control group)	Timing of Substance Abuse Assessment	Party(ies) Responsible for Assessment	Assessment Instrument(s)
Delaware	Following maltreatment investigation and determination that alleged substance abuse represents a threat to child safety.	Following CPS case opening.	CPS case manager and/or substance abuse counselor.	Parental Substance Abuse Inventory
Illinois	At time of referral for substance abuse treatment. Parents for whom treatment is indicated are randomly assigned to the experimental or control group.	Within 90 days following Temporary Custody Hearing and prior to referral for treatment and assignment to demonstration.	Substance-abuse assessment counselors employed through Illinois' JCAP program.	AODA ⁴ assessment protocol in accordance with ASAM ⁵ criteria.

Maryland	After CPS case opening and following screening by a specialized intake worker to determine program eligibility. Eligible women were randomly assigned to the experimental or control group.	Following eligibility screening and assignment to Family Support Services Team (FSST).	Joint assessment by chemical addiction counselor and child welfare case manager.	<ul style="list-style-type: none"> • Mini-Mental Status Examination • Comprehensive Addictions and Psychological Evaluation (CAAPE) • Parenting Stress Inventory (PSI) • Achenbach Child Behavior Checklist • Structured Interview
New Hampshire	At time of initial maltreatment report; prior to maltreatment substantiation or CPS case opening.	After assignment to the experimental group (enhanced substance abuse services).	Licensed Alcohol and Drug Abuse Counselor (LADC).	Substance Abuse Subtle Screening Inventory (SASSI)

Delaware

Delaware adopted a less structured, open-ended process of case intake and substance abuse assessment, in which screening and assessment could occur throughout the life of the case and involve multiple professionals in a CPS unit. The intake process for demonstration participants began with a CPS unit's child protection investigative worker, who screened caregivers with a report of alleged child maltreatment for suspected or documented substance abuse issues. To facilitate identification of these caregivers, the investigative worker administered a brief screening tool called the Simple Screening Instrument. If the screening indicated that suspected or documented substance abuse by a caregiver posed a threat to the child's safety, the caregiver was then referred for CPS case management services. Once assigned to a CPS unit, either a CPS caseworker or the co-located substance abuse counselor conducted a more in-depth assessment of the caregiver's substance abuse problems using a tool known as the Parental Substance Abuse Risk Inventory. With a more detailed profile of the client's substance abuse behaviors and needs, the CPS case manager then coordinated with the substance abuse counselor to link the client to substance abuse treatment and support services and to monitor the clients' progress in entering and completing treatment.

Illinois

Illinois developed a rigorously structured enrollment and assessment process for its waiver demonstration, with assessment occurring prior to a caregiver's referral for treatment services and assignment to the substance abuse waiver demonstration. As mentioned earlier, Illinois' demonstration only targets caregivers with alleged or documented substance use disorders who already have a child in out-of-home placement. The demonstration's intake process begins following a temporary custody hearing, at which time the State gains legal custody of the child and assigns the family to a child welfare agency for services. At the time of the hearing or within 90 days thereafter, the judge, case worker, or attorney may refer the caregiver to the Juvenile Court Assessment Program (JCAP), a project established by the Illinois Department of Children and Family Services to assess the nature and severity of caregivers' substance abuse issues and to make appropriate treatment referrals.

Through JCAP, caregivers undergo substance abuse assessments administered by privately contracted, licensed chemical dependency counselors working on-site at the juvenile court. Chemical dependency counselors conduct the assessments in accordance with criteria developed by the American Society of Addiction Medicine (ASAM); all eligible caregivers, regardless of whether they are later assigned to receive enhanced substance abuse services or traditional services, participate in this assessment process. Following the assessment, the counselor makes a same-day referral to a substance abuse treatment provider if indicated. It is at this point that enrollment into the State's waiver demonstration occurs: caregivers assigned to agencies in the experimental group receive traditional child welfare services plus the enhanced services of a Recovery Coach, whereas caregivers assigned to agencies in the control group receive only traditional child welfare services.

Maryland

Maryland's intake and substance abuse assessment process was similar to Delaware's process in that assessments occurred following assignment to the demonstration and were conducted jointly by child protection case managers and substance abuse specialists. To determine eligibility for the project, Maryland designated specialized case screeners to review the files of women in participating jurisdictions with open CPS cases; women with a stated or suspected substance use disorder who had a child in or at-risk of out-of-home placement were deemed eligible to participate in the project. The screeners then forwarded eligible cases to an independent evaluation contractor, who randomly assigned women to the experimental group or to a control group. Upon assignment to the experimental group, mothers were referred to the Family Support Services Team (FSST) for substance abuse assessment and referral for treatment services. Once referred to the FSST, the team's case manager and chemical abuse counselor were to conduct a joint assessment of the needs of all family members, including a determination of the extent of the mother's substance use disorder and its impact on her ability to ensure the safety and well-being of her children. Maryland planned to use a highly comprehensive and global assessment protocol that evaluated the children and mothers' intellectual functioning and the mother's psychosocial and psychiatric history as well as the prevalence and severity of substance abuse. In its proposed assessment protocol, Maryland included the Mini-Mental Status Examination, the Comprehensive Addictions and Psychological Evaluation (CAAPE), the Parenting Stress Inventory (PSI), the Achenbach Child Behavior Checklist, and a specially designed structured

interview. Only caregivers assigned to the experimental group were to undergo this extensive assessment process.

New Hampshire

New Hampshire's intake and assessment process differs from the processes in other States in that families are enrolled in the demonstration immediately at the time of an initial maltreatment report, prior to completion of a maltreatment assessment and CPS case opening. Following receipt of this abuse or neglect report, the State's evaluation contractor at the University of New Hampshire randomly assigns families to the experimental group or to the control group. Experimental group families have access to enhanced substance abuse services through a Licensed Alcohol and Drug Abuse Counselor (LADC) working in conjunction with a child protection worker. Caregivers in the control group receive traditional child protection and substance abuse referral services. The caregiver's formal substance abuse assessment occurs following assignment to the demonstration and is conducted by the LADC using the Substance Abuse Subtle Screening Inventory (SASSI). As in the case of Delaware and Maryland, only caregivers assigned to the experimental group undergo a formal and immediate in-house substance abuse assessment. For control group caregivers, the administration of a substance abuse assessment by a child protection worker or a contracted out-of-office counselor is done at the discretion of each caregiver's child protection worker.

New Hampshire designed its enrollment procedures in response to its unique characteristics as a largely rural State with a comparatively small child welfare population. In New Hampshire, only 15 percent of maltreatment reports typically result in an abuse or neglect substantiation; of these substantiated cases, only half require court involvement. In addition, the length of the maltreatment assessment process in New Hampshire - up to 60 days - further slows the rate at which maltreatment reports are substantiated and CPS intervention is ordered. Thus, it would have been difficult to enroll adequate numbers of parents in the demonstration if eligibility were limited to substantiated cases with a court order for CPS involvement. Given these considerations, the State decided in advance of the waiver's implementation that the enrollment and assessment of caregivers with a potential substance use disorder should begin sooner rather than later.

²Aid to Families with Dependent Children, the predecessor to the current Federal Temporary Assistance to Needy Families (TANF) program.

³In 2004 and 2005 three additional States - Arizona, Minnesota and Wisconsin - received approval for, but have not yet implemented, their child welfare waiver demonstrations.

³Alcohol and Other Drug Abuse.

³American Society of Addiction Medicine.

Evaluation Methodologies

The Children's Bureau requires that States granted title IV-E waivers conduct rigorous evaluations that include process and outcome components. In terms of process evaluation, each State implementing a substance abuse demonstration focused on different issues, although most addressed staffing, personnel, and organizational factors that affected implementation. For the outcome evaluation component, most States sought answers to a similar set of questions, including whether their waiver demonstrations reduced children's length of time in foster care and increased reunification rates. Beyond these core outcomes, New Hampshire and Illinois studied the success of their projects in reducing the incidence of subsequent maltreatment and in improving placement stability, defined as the frequency with which children in foster care changed placement settings.

Table 3 summarizes the major features of the States' evaluations, including research designs and sample sizes. The table highlights the limitations of some States' evaluations and places caveats on the subsequent interpretation of evaluation findings, particularly with respect to child welfare outcomes. Maryland, for example, terminated its demonstration early and assigned very few families to its demonstration. Consequently, it reported no outcome data and the discussion of its evaluation in this paper is limited to process findings. Delaware relied on a comparison group design to examine differences in outcomes for clients in child protection units with a substance abuse counselor (experimental group) compared with outcomes for clients in matched units without a substance abuse counselor (comparison group). Each of Delaware's three counties had one experimental child protection unit and one matched comparison unit. However, because CPS staff in comparison units were housed in the same office as CPS staff in experimental units, contact between comparison unit child protection workers and substance abuse counselors may have occurred, thereby contaminating Delaware's research design and weakening the validity of its reported outcomes. In addition, Delaware and Maryland's research samples included both cases in which one or more children were in or entered out-of-home placement as well as cases in which all children remained home. The inclusion of both in-home and out-of-home cases in these States' research samples potentially skews the interpretation of key outcome measures (for example, placement duration) if subpopulation analyses are not conducted to link appropriate outcome measures with each subpopulation.

Although Illinois and New Hampshire have not yet completed their demonstrations or reported final evaluation results, this paper will focus its discussion of outcome findings on these two States because of the comparative strength of their research designs and greater availability of outcome data. However, because of their considerable differences in size, population characteristics, levels of urbanicity, availability of substance abuse treatment resources, and child welfare laws and policies, the reader should exercise caution in making comparisons across the States regarding the effectiveness of their substance abuse waiver demonstrations in improving child welfare outcomes.

Table 3
Evaluation Designs of Substance Abuse Waiver Demonstrations

State	Research Design	Sample Size (# of Cases)					
		Experimental Group			Control/Comparison Group		
		In-home cases ⁶	Out-of-home cases	Total	In-home cases	Out-of-home cases	Total
Delaware	Comparison group	398	132	530	368	162	530
Illinois ^{<}	Random assignment	Not applicable	954 as of 6/30/04	954	Not applicable	366 as of 6/30/04	366
Maryland	Random assignment	--	--	9 ⁷	--	--	9
New Hampshire	Random assignment	183	39	222	182	33	215

State Process Evaluations - Summary of Key Findings and Issues

Process findings from the States' substance abuse waiver demonstrations can be analyzed across several dimensions:

- Parental characteristics;
- Project referral and enrollment;
- Treatment access;
- Treatment retention and completion;
- Data collection and tracking; and
- Other implementation issues, including staff training, worker turnover, and the differing professional philosophies of child welfare workers and substance abuse specialists.

These dimensions highlight the unique context in which each substance abuse project operated and the special challenges encountered by States in realizing the goals of their waiver demonstrations.

Parental Characteristics

Of the four States with substance abuse waivers, only New Hampshire and Illinois provided detailed information on the demographic characteristics of parents being served through their waiver demonstrations. A comparison of caregiver profiles from these States reveals striking differences; although the age and gender of parents were similar, major distinctions emerge in

terms of race, the mix of presenting problems, and types of abused substances. As illustrated in Table 4, caregivers in New Hampshire's project were overwhelmingly white, were more likely to abuse alcohol or marijuana, and most frequently entered the child welfare system due to a neglect allegation. An analysis of families in the experimental group seen by Licensed Alcohol and Drug Abuse Counselor (LADC) showed a significant association ($p < .05$) between a diagnosis of chemical dependency and the maltreatment disposition of the case; a substantiation of abuse or neglect was more likely in cases in which the SASSI score indicated the presence of substance abuse. New Hampshire then conducted a logistic regression analysis to identify the factors that might contribute to case substantiation. This analysis indicated several contributing variables, including the number of alcohol-related factors as measured by MAST⁸ scores; a history of illicit drug use beyond marijuana; depression; and neglect as the presenting type of maltreatment.

In contrast to New Hampshire, participants in Illinois' demonstration were largely African American, were more likely to abuse cocaine or opioid drugs, and more likely entered the child welfare system after giving birth to a substance-exposed infant. These differences highlight the unique circumstances and population characteristics that States must address when confronting the issue of substance use, abuse, and dependency.

Table 4 Characteristics of Caregivers in Substance Abuse Waiver Demonstrations

Variable	New Hampshire	Illinois
Mean Age	33	31
Gender	87% Female	71% Female
Race	90% Caucasian	81% African American
Presence of Mental Health Issues	18% ⁹	28%
Top Three Drugs Used (in order of prevalence)	<ol style="list-style-type: none"> 1. Alcohol 2. Marijuana 3. Cocaine 	<ol style="list-style-type: none"> 1. Cocaine 2. Opioids 3. Alcohol
Usage Rate for Top Drug	Alcohol - 40% of caregivers reported having four or more drinks at any given time	Cocaine - 38% of caregivers reported using cocaine several times per week
Top Two Presenting Problems	<p>54% - Neglect</p> <p>23% Physical Abuse</p>	<p>31% - Substance Exposed Infant</p> <p>21% - Substantial Risk of Physical Abuse/Harm</p>

Project Referral and Enrollment

Each State's decision to implement a substance abuse waiver demonstration rested on the assumptions that (1) a sizeable number of substance-abusing parents resided in the State who represented a threat to the safety and well-being of their children, and (2) that these caregivers would agree to assessment and treatment if these services were offered through a substance abuse waiver (i.e., "build it and they will come"). However, the challenges experienced by States in implementing their waiver demonstrations call these basic assumptions into question and underscore the need to refine screening processes and eligibility criteria to facilitate the achievement of States' implementation goals.

Delaware

In its initial project proposal, Delaware outlined plans to refer five families per CPS unit per month (or 15 families statewide per month) to receive enhanced substance abuse services, for a total of 180 families per year and 900 families over the course of its demonstration. However, the State noted in its final evaluation report that it never established formal screening and review procedures to ensure the minimum of five monthly referrals per unit. The flow of referrals remained highly sporadic throughout the course of the demonstration, and by the conclusion of the project, only 530 families – 55 percent of the expected number – had received enhanced substance abuse services. Delaware concluded in its report that CPS units in which supervisors took an active role in reviewing cases for indications of a substance use disorder and in directly referring cases to substance abuse counselors had the smoothest, most consistent referral processes. Adequate supervisory oversight had not evolved in most CPS units until the fourth year of the demonstration, rendering attainment of the State's original referral goals unlikely. In addition, the State found that it had underestimated the average length of time that experimental group cases would remain open. In its final evaluation report, the State noted that closed experimental group cases had remained open for an average of nine months, three times longer than the original estimate of three months. Substance abuse counselors identified the complex nature of most cases as the primary reason for their long service lives, with the typical caregiver having had lengthy histories of substance abuse or addiction, several failed recovery attempts, and expressing resistance both to further treatment and denial regarding the severity of their substance use disorder. The longer-than-expected lives of many cases further limited the number of new referrals that Delaware's waiver demonstration could absorb.

Illinois

Illinois' actual experience with project referrals and enrollment belied its original projections about the availability of eligible families. Using a monthly average of 195 families entering the foster care system in Cook County, the State estimated in its waiver proposal that about 50 percent would involve either a substance-exposed infant or serious drug use by parents, producing an estimate that approximately 100 families per month (1,200 per year) would be

suitable candidates for the demonstration. However, the State noted in its interim evaluation report that its initial assumptions regarding the number of JCAP referrals and the size of the potentially eligible target population were erroneous. First, the juvenile courts made far fewer referrals to JCAP than expected during the first two years of the demonstration, with only 469 occurring in FY 2000 and 608 in FY 2001. Second, although the JCAP assessments indicated treatment in more instances than the State initially predicted, a smaller percentage than expected met the demonstration's eligibility requirement of obtaining an assessment within 90 days of the temporary custody hearing. According to the State's November 2004 report, on average only 50 percent of assessed caregivers for whom treatment was indicated met the demonstration's eligibility requirement of obtaining a substance abuse assessment within 90 days of the temporary custody hearing. A third factor affecting the accuracy of the State's enrollment predictions involved the sharp drop in the total child welfare caseload in Cook County, Illinois. Between the end of Fiscal Year 2001 and March 2005, the total, unduplicated number of children involved in the county's child welfare system declined from 20,320 to 11,920.¹⁰

Illinois' miscalculations regarding the number of JCAP assessments and eligible clients initially depressed enrollment into the waiver demonstration; by the project's mid-point in 2003, only 528 caregivers had been assigned to receive enhanced substance abuse services, far less than 50 percent of the State's target of assigning 1,500 caregivers to the experimental group by project's end. Since then, the State has made up much lost ground as the number of JCAP assessments has increased to over 1,000 annually in Fiscal Years 2002 through 2004. As of November 2004, the proportion of initial assessments resulting in treatment referrals has stabilized at approximately 61 percent and a total of 954 caregivers have been assigned to the demonstration's experimental group. The State attributes this still somewhat low percentage of treatment referrals to clients' inaccuracy in self reporting, which may result in a failure to meet the specific criteria that indicate a need for treatment.

Maryland

Among the States with substance abuse waivers, Maryland experienced the greatest difficulties with client referral and enrollment. At the time the State terminated its demonstration project, only nine women had been assigned to the experimental group and only eight ever received enhanced substance abuse services. In its October 2002 progress report, Maryland described a study of 913 cases screened between October 1, 2001 and August 31, 2002 for eligibility to participate in the waiver demonstration; the results of this analysis revealed that the State had made erroneous assumptions regarding the eligibility and recruitment potential of its proposed target population. For example, the State discovered that cases with a documented or suspected substance use disorder comprised only 31 percent of all screened cases. Of the 283 cases in which a substance use disorder was identified, the majority were ineligible to participate in the demonstration because of pre-defined disqualifying criteria, including participation in another substance abuse project, the presence of mental health problems, an allegation of sexual abuse, child abandonment, or unavailability of the caregiver (e.g., due to incarceration or unknown whereabouts). At the end of its analysis, the State identified only 27 caregivers with a known substance use disorder who were not otherwise disqualified or unavailable to participate in the demonstration. The difficulties experienced by Maryland in identifying and enrolling eligible caregivers speak both to the considerable challenges of serving substance-abusing parents with

multiple co-occurring problems and to the importance of establishing a clear understanding of the characteristics of the population targeted for waiver services.

New Hampshire

Like Illinois in the earlier phases of its demonstration, New Hampshire encountered problems in getting caregivers assigned to the experimental group to complete a substance abuse assessment. As of the State's September 2003 interim report, only 122 of 222 experimental group caregivers (58 percent) had completed a substance abuse assessment. The State suggests that these low assessment rates may result from the voluntary nature of the substance abuse assessment. Because the majority of maltreatment investigations in New Hampshire do not result in maltreatment substantiation and a subsequent CPS case opening, the State has no basis for requiring caregivers to undergo a substance abuse assessment and enroll in treatment as a condition for allowing their children to remain home or return home from foster care. Thus, many experimental group caregivers may simply decline to participate in the assessment or seek substance abuse treatment. According to New Hampshire's March 2004 progress report, 86 percent of maltreatment investigations involving cases assigned to the experimental group were unsubstantiated, leading the State to close them without the ability to require further assessment or services.

Treatment Access

All four States with substance abuse waivers sought to provide caregivers enrolled in their demonstration with rapid access to substance abuse treatment and support services. Illinois' demonstration experienced the greatest success in connecting caregivers to treatment services, whereas other States, particularly Delaware, faced several obstacles that may have limited clients' timely access to treatment.

Delaware

By the end of Delaware's initial five-year waiver demonstration in February 2002, only 168 of 420 closed experimental group cases (about 40 percent) had made at least initial contact with a treatment provider. In the remaining closed cases, substance abuse counselors were unsuccessful in connecting clients to a treatment provider (125, or 30 percent), CPS closed the case after losing contact with the client (104, or 25 percent), treatment was not needed (17, or 4 percent), or the client refused treatment services (3, or less than 1 percent). The State attributed these modest treatment access rates to several factors, including high staff turnover during which the project lost contact with many clients, client resistance to treatment, and the limited availability of appropriate treatment options for substance-abusing women. Specifically, Delaware noted the paucity of residential and intensive outpatient programs in the State, particularly for pregnant women, clients with dual diagnoses, or that provide housing for women and their children.

Illinois

Illinois succeeded in linking most experimental group clients to treatment resources, in part due to an aggressive intervention strategy that sought to connect clients to a Recovery Coach within

48 hours of the initial substance abuse assessment. According to the State's interim evaluation report, the proportion of referred parents who had contact with a Recovery Coach rose gradually and stabilized at around 90 percent by the first quarter of 2003. The immediate involvement of a Recovery Coach appeared to have a positive effect on access to treatment services, with the State's November 2004 progress report revealing a statistically significant difference between the proportion of parents accessing treatment services in the experimental group (73 percent) and the proportion in the control group (50 percent). In addition, caregivers who received enhanced waiver services accessed treatment more quickly, with 50 percent of parents in the experimental group experiencing a first treatment episode within 40 days compared with 100 days for 50 percent of control group parents, a statistically significant difference.

Maryland

In Maryland, substance abuse counselors sought to connect women assigned to the experimental group to treatment resources as soon as a substance use disorder was either stated or implied. Although the State enrolled very few women into the waiver demonstration, most of those assigned to the experimental group had entered a treatment program by the time the waiver was terminated in December 2002. Of the nine women assigned to the experimental group, three were receiving outpatient substance abuse treatment and three had enrolled in six-month inpatient treatment programs. Of the remaining women, one was incarcerated and demonstration staff had lost track of two.

New Hampshire

The latest findings from New Hampshire indicate similar levels of access to substance abuse treatment services by experimental and control group caregivers. According to a recent review of interview data collected from subjects enrolled in its waiver demonstration, 26 percent of experimental group caregivers (n = 101) had received substance abuse treatment services compared with 24 percent of caregivers in the control group (n = 106). Among cases with a substantiated allegation of maltreatment, however, the most recent data suggest that experimental group caregivers are more likely to access intensive, long-term treatment services. To date, almost 20 percent of experimental group caregivers with a substantiated maltreatment allegation have received long-term inpatient substance abuse treatment services compared with six percent of control group caregivers, a statistically significant difference.¹¹

Treatment Retention and Completion

Among the four States, only Delaware and Illinois collected specific data on the numbers of enrolled caregivers who have remained in or who have successfully completed substance abuse treatment. Illinois has enjoyed modest success in facilitating clients' engagement in and completion of treatment. As of June 30, 2004, 132 of 376 active clients assigned to the experimental group (35 percent) were engaged in treatment, while 91 clients (24 percent) had successfully completed treatment. The remaining caregivers had dropped out of treatment, were pending initial treatment, or could not be located to begin treatment. Of the 132 clients actively engaged in treatment, 53 (40 percent) had been receiving treatment services for six months or more. The State noted in its November 2004 progress report that parents' likelihood of

completing treatment is higher if they remain engaged in treatment for at least 90 days. Of all 954 parents assigned to the experimental group from the beginning of the demonstration through June 30, 2004, 73 percent (697) had participated in treatment at some point in time compared with only 50 percent (182) of the 366 parents assigned to the control group.

Illinois' success in engaging caregivers in treatment is notable in light of the State's historically low treatment enrollment and completion rates. A 1998 GAO report found that among mothers in Cook County with AODA problems whose children had been in foster care for over 12 months, just over 20 percent had completed or were actively enrolled in treatment. Almost 40 percent of these mothers had never entered treatment and the remainder had either dropped out or had otherwise failed to complete treatment.

Delaware experienced more difficulties with retaining clients in treatment. By the end of the State's waiver demonstration in February 2002, only 101 of 420 closed experimental group cases (24 percent) were enrolled in or had completed treatment; the State did not provide a specific breakdown of clients engaged in treatment versus those who had completed treatment at the time the demonstration ended. Delaware's more limited success in retaining clients in treatment is understandable given the resource constraints and implementation barriers that reduced treatment access in that State.

Data Collection and Tracking

All four States cited varying degrees of difficulty in collecting and tracking demographic, social service, and treatment information on caregivers enrolled in the waiver demonstrations. These difficulties affected both the smoothness of project implementation and the quality of data available for evaluation.

Delaware

Antiquated or inadequate information systems hampered the collection of data for Delaware's waiver evaluation. Specifically, the State noted in its final 2002 progress report that its existing child welfare information management system lacked the capacity to track historical case data. To overcome the limitations of its existing information system, the State turned to ad hoc data reporting tools such as Microsoft Access to generate monthly evaluation reports. The effort required to generate ad hoc evaluation reports "from scratch" consumed the time and resources of both the State's independent evaluator and of its waiver project staff and delayed the reporting of waiver findings.

Illinois

Illinois has provided thorough documentation regarding its efforts to collect and track data regarding its waiver participants. In its November 2004 progress report, Illinois described particular problems with obtaining informed consent from enrolled caregivers to review other case data pertinent to the State's evaluation, such as public assistance history and mental health records. As of June 30, 2004, only 32 percent of all caregivers enrolled in the demonstration had signed research consents granting permission to review their case records. The State's attempts to

redesign the consent form to clarify the language regarding informed consent have done little to increase consent rates. In short, when participation in research is voluntary, most caregivers choose not to grant access to confidential information. Low rates of informed consent have limited the scope of research regarding issues relevant to the waiver evaluation, such as clients' mental health status and use of other social services.

Illinois has experienced more success in collecting data on the substance abuse treatment histories of caregivers enrolled in its demonstration. The State uses a specialized database called the Treatment Record and Continuing Care Systems (TRACCS) to track treatment data on caregivers in both the experimental and control groups. TRACCS forms are sent to child welfare workers for completion on a quarterly basis and to substance abuse providers and Recovery Coaches on a monthly basis. As of June 2004, child welfare workers and Recovery Coaches had completed and returned about 80 percent of their TRACCS forms; completion rates for substance abuse providers are substantially lower at only 60 percent. In an effort to improve TRACCS completion rates, Illinois has scheduled additional trainings regarding TRACCS and has redesigned the TRACCS form for greater simplicity and ease of use.

Maryland

In its September 2002 progress report, Maryland described difficulties both with obtaining informed consent from caregivers and with tracking referrals to the waiver demonstration. Through a series of focus groups conducted by the State's waiver evaluators, project staff noted a lack of clarity regarding the worker responsible (i.e., the child welfare caseworker or the addiction specialist) for describing the evaluation to caregivers and obtaining consent to participate in research. In fact, almost no focus group participants had even seen the research consent form for the waiver evaluation. In addition, focus group participants identified several problems with tracking referrals to the substance abuse waiver demonstration. Intake workers who screened caregivers usually did not follow cases once they had determined their eligibility to participate in the waiver, while Family Support Service Team members noted that they seldom received copies of client intake reports. This lack of continuity in the client referral process often produced duplication or interruptions in the collection of data on caregivers enrolled in the demonstration.

New Hampshire

Because the vast majority of maltreatment referrals in New Hampshire are resolved without a maltreatment substantiation and do not result in a child protection case opening, the State's evaluators have expressed concerns about their ability to track basic process data on clients, including their completion of substance abuse assessments and participation in treatment services. To address these concerns, evaluation staff from the Family Research Lab at the University of New Hampshire have developed a client follow-up protocol and interview tool that they hope will fill gaps in client assessment and treatment data once families leave the child welfare system. The State's final evaluation report may shed additional light on the success of this protocol in collecting follow-up data on waiver participants with closed child protection cases.

Other Implementation Challenges

Worker Training and Education

Inadequate education regarding the waiver demonstrations and lack of training in the identification and assessment of substance abuse contributed to the difficulties with caregiver enrollment and retention described above. Focus groups held with caseworkers in Maryland revealed several gaps in worker education that impeded caregiver recruitment into the waiver demonstration. Specifically, many child welfare workers in Maryland reported that they were unfamiliar with the waiver's purpose and eligibility criteria and were unclear about the distinction between the waiver demonstration and other substance abuse treatment projects in the State. In addition, focus group participants questioned whether intake workers with child welfare backgrounds had the appropriate skills and training to identify substance use disorders, an issue that may have contributed to low enrollment rates in Maryland's demonstration. Caseworkers in one Maryland county estimated that substance use disorders were not discovered in 90 percent of all cases until they had left intake and been transferred to a child welfare case manager; if true, these cases would have missed the recruitment window established at child welfare intake for enrollment into Maryland's waiver demonstration.

Like Maryland, Delaware cited inadequate training for child welfare caseworkers in the identification of and appropriate responses to caregiver drug and alcohol abuse as a major obstacle to waiver implementation. Delaware noted in its final evaluation report that over time, caseworkers' knowledge of substance use disorders increased through interactions and joint case management with substance abuse counselors.

Illinois' experience highlights the importance of frequent worker training and follow-up to maximize the availability of quality evaluation data. After observing low completion rates of the TRACCS data collection tool by substance abuse treatment providers, Illinois scheduled additional trainings at each provider site regarding the proper completion of the tool. After implementing supplemental trainings, the completion rate of TRACCS forms by treatment providers increased from 54 percent in December 2003 to 60 percent in June 2004, while the accuracy and timeliness of form submission improved as well. In addition, waiver staff met with Juvenile Court personnel - including judges, state attorneys, public defenders, and guardians ad litem - on a regular basis to familiarize them with the demonstration. As these trainings and meetings progressed, interagency communication improved and both court staff and treatment providers gained a better understanding of the demonstration and optimal strategies for implementing it.

Staff Turnover

In some States, high turnover among staff involved in the waiver demonstration exacerbated the problems with worker training and education noted above. Delaware, for example, noted in its final evaluation report that high staff turnover slowed efforts to integrate substance abuse counselors into CPS agency operations and to promote a joint case planning approach to serving enrolled families. One Delaware County experienced extremely high turnover, employing five substance abuse counselors over the course of the demonstration and coping with one year-long

vacancy in this position. High turnover among substance abuse counselors in some Maryland jurisdictions impeded the smooth implementation of substance abuse services. Similarly, New Hampshire reported in a July 2002 progress report that turnover in substance abuse treatment counselors in one CPS office made it difficult for that office to maintain fidelity to the demonstration's original treatment model. Over a six month period, this office only had part-time assistance from a counselor in another CPS office while it searched for a qualified applicant to fill the vacant full-time position.

Differences in Management Styles and Professional Philosophies

Differences in the management styles of CPS supervisors and in the professional philosophies of child welfare caseworkers and substance abuse counselors further hindered waiver implementation in some States. These conflicts were most apparent in Delaware and Maryland and tended to reflect resistance to new case management models or the differing professional foci of child welfare and substance abuse workers. In Delaware, the likelihood of successful service coordination depended in part on the extent to which CPS unit supervisors involved the substance abuse counselor in case planning and decision making; however, the unit supervisor in the State's largest county preferred to maintain a clear separation between substance abuse services and child welfare services, thus prohibiting effective joint case planning. In contrast, another Delaware County implemented the key elements of the waiver model quickly and completely in part due to the unit supervisor's commitment to the joint case planning model and a balanced supervisory approach that integrated the substance abuse counselor more fully into unit operations.

Both Delaware and Maryland noted the challenges of implementing a successful substance abuse waiver in light of the differing philosophical traditions of child welfare workers and substance abuse professionals. In Delaware, this philosophical clash manifested itself in the differing emphases of child welfare caseworkers and substance abuse counselors in case planning and goal development, with child welfare workers stressing child safety and "reduction in harm" and substance abuse counselors emphasizing drug and alcohol abstinence. For many substance abuse counselors, anything short of complete abstinence by clients was regarded as a failure, whereas child welfare workers were more willing to tolerate some level of substance use - particularly involving alcohol or marijuana - if they perceived that overall child safety and well-being had improved.

In its final evaluation report, Delaware noted that ongoing training for substance abuse counselors and child welfare workers increased their mutual understanding and appreciation of their respective professional traditions and enhanced integration of both philosophies in case planning and decision making. Over time, substance abuse counselors began to integrate a "reduction in harm" approach into their work, while child welfare workers responded more seriously to alcohol and marijuana use by caregivers. In Maryland, a similar disconnect in professional perspectives became an obstacle to collaborative case planning by child welfare workers and addiction specialists, with some child welfare workers perceiving addiction specialists as emphasizing the recovery and treatment needs of the caregiver over the safety and well-being of children.

Summary of Process Findings

Although all four waiver States experienced varying degrees of difficulty in recruiting caregivers to participate in their substance abuse demonstrations, the available evaluation findings - especially from Illinois - suggest that intensive, proactive case management can enhance access to treatment services for substance-abusing caregivers and may have a modest positive impact on treatment retention and completion rates. Delaware's experience, however, highlights the critical importance of quality substance abuse treatment resources in improving treatment access and retention. The challenges faced by the States with caregiver enrollment highlight the need to test basic assumptions regarding the identification of substance use disorders in child welfare populations and caregivers' availability, motivation, and willingness to participate in treatment. Furthermore, these challenges make clear the importance of carefully defining target populations, eligibility criteria, and intake screening procedures. Finally, the experiences of all four States underscore the need to address data collection and reporting issues early in waiver planning and implementation, particularly with respect to obtaining informed consent from clients and completing substance abuse assessments.

State Outcome Evaluations - Summary of Key Findings and Issues

States with substance abuse waivers have reported varying degrees of success in achieving their goals with respect to key child welfare outcomes. As summarized in Table 5, Illinois and New Hampshire reported data on several outcomes of interest. Delaware chose to focus on a more limited number of evaluation outcomes, namely with respect to placement rates and placement duration. Maryland, which terminated its demonstration early, did not report outcome findings.

Table 5
Summary of Outcomes Studied By States with Substance Abuse Waiver Demonstrations

Outcomes	Delaware	New Hampshire	Illinois
Foster Care Placement Rates	Studied	Studied	Not Applicable
Placement Stability	Not Studied	Studied	Studied
Placement Duration	Studied	Studied	Studied
Reunification and Permanency Rates	Not Studied	Studied	Studied
Subsequent Maltreatment	Not Studied	Studied	Studied
Family and Child Well-Being	Not Studied	Studied	Not Studied

Reducing Placement Rates

Delaware and New Hampshire studied the effects of their substance abuse waivers on foster care placement rates, defined as the proportion of in-home children enrolled in the demonstration who

later entered out-of-home placement. To date, neither State has found conclusive evidence that access to enhanced substance abuse services reduces rates of foster care placement.

Delaware

Delaware reported that across all three participating counties, somewhat smaller percentages of children in CPS units with access to enhanced substance abuse services entered placement than children in CPS units without access to enhanced services. In New Castle County, the placement rates were 28 percent for the experimental group and 31 percent for the control group; in Kent County, 19 percent and 25 percent, respectively; and in Sussex County, 25 percent and 34 percent, respectively. The effects of the waiver on these small differences in placement rates remain unclear, although the State suggested in its final evaluation report that the lower placement rates among experimental group children could have resulted in part from access to enhanced substance abuse services. Among experimental group families, those in New Castle County experienced the highest overall placement rates. The factors underlying this higher placement rate are unclear, although Delaware's process evaluation uncovered significant implementation problems in New Castle County - including high staff turnover and lack of joint case planning - that may have limited the quantity and quality of demonstration services.

New Hampshire

Like Delaware, New Hampshire has documented no definitive, significant variations in placement rates between families receiving enhanced substance abuse services and those receiving traditional child welfare services. Overall, 39 of 51 experimental group families (76 percent) that ever had an open CPS case during the waiver demonstration had at least one child enter placement, compared with 33 of 50 control group families (66 percent) that ever had an open CPS case.

Increasing Placement Stability

Illinois and New Hampshire both studied the effects of their waiver demonstrations on placement stability. Illinois defined placement stability in terms of the average number of times a child in foster care changes placement settings. To date, Illinois has found no evidence that access to enhanced substance abuse services improves placement stability for children in foster care. According to the State's May 2003 interim evaluation report, experimental group children had experienced an average of 3.67 placements as of March 2003 compared with 3.79 placements for control group children; this difference was not statistically significant. New Hampshire uses a somewhat different measure than Illinois to measure placement stability, tracking placement episodes on a per case rather than on a per child basis. Like Illinois, New Hampshire has observed no statistically significant effects of its demonstration on placement stability, with the State's latest data indicating an average of 3.06 placements per case in the experimental group compared with 3.70 placements per case in the control group. ¹²

Reducing Placement Duration

The States have revealed more definitive positive findings regarding the effects of the substance abuser waiver on reductions in the length of out-of-home placements, with Illinois uncovering the most conclusive evidence to date.

Delaware

Delaware reported that across all three implementation sites, children in the experimental group who entered out-of-home placement spent less time in foster care than those in the comparison group - an average of 204 days versus an average of 294 days. Although these figures suggest a major decline in average placement stays, the decrease fell short of the State's original goal of cutting the average duration of out-of-home placements by 50 percent. More significantly, Delaware included both in-home cases and out-of-home cases in its placement statistics, which skews the calculation of average placement length by including cases that experienced no time in placement. Thus, the State's figures may overstate the variance in placement duration between the experimental and comparison groups.

Illinois

Illinois' latest evaluation findings suggest that children in families with access to intensive substance abuse services spend measurably less time in foster care. According to the State's November 2004 progress report, children in the experimental group who returned home attained permanency in substantially less time than children in the control group, spending an average of 421 days in out-of-home care compared with 563 days for control group children, a statistically significant difference of 142 days. Although not statistically significant, the State also found that experimental group children exiting to adoption spent less time in out-of-home care, achieving permanency on average in 1,099 days compared with 1,128 days for control group children.

New Hampshire

The latest findings from New Hampshire are mixed, but suggest that no significant differences in placement duration exist between families receiving enhanced substance abuse services and those receiving traditional child welfare services. As of December 2004, the average length of placement per child among experimental group cases in which a child had been removed from the home was 287 days, somewhat higher than the 260 days for children in control group families. Although these findings suggest that experimental group children on average spent slightly more time in out-of-home placement than control group children, this difference is not statistically significant. Furthermore, small sample sizes could affect the ability of New Hampshire's evaluation to detect the effects of the demonstration on length of placement.

Increasing Reunification and Permanency Rates

Illinois

To date, no State has reported conclusive positive results regarding the effects of its substance abuse demonstration on reunification or overall permanency rates. In its November 2004 progress report, Illinois indicated that 10.3 percent of children in closed experimental group

cases had returned home compared with 7.7 percent of children in closed control group cases. When all forms of permanency (defined as reunification, adoption, and guardianship) are compared, 20.8 percent of children in closed experimental group cases achieved permanency compared with 19.8 percent of their control group counterparts. While suggesting a positive trend, neither difference was statistically significant. These latest data contradict findings from the State's earlier June 2004 progress report, which indicated that experimental group children were more likely to achieve reunification or another permanency outcome at statistically significant levels. Illinois' final evaluation report, expected in December 2005, may offer a more definitive answer regarding the effects of the State's substance abuse waiver on reunification and overall permanency rates.

New Hampshire

The available data from New Hampshire likewise suggest no major effects of its substance abuse demonstration on reunification rates. As reported in the State's September 2003 interim report, 12 of 41 experimental group children (29 percent) who entered or began the demonstration in placement returned home, compared with 11 of 41 control group children (27 percent) who were in or entered placement.

Preventing Subsequent Maltreatment

Illinois and New Hampshire evaluated the effects of their substance abuse waiver demonstrations on maltreatment recurrence. The latest findings from Illinois indicate that families with access to enhanced substance abuse services may experience reduced risk of subsequent maltreatment. To date, New Hampshire has uncovered no effect of its waiver demonstration on the likelihood of subsequent maltreatment referrals.

Illinois

As of June 30, 2004, only 11.2 percent of experimental group caregivers in Illinois' demonstration had a subsequent maltreatment allegation following assignment to the demonstration compared with 15.3 percent of control group caregivers, a statistically significant difference.¹³

New Hampshire

As of March 2004, 43.7 percent of experimental group cases in New Hampshire had a subsequent allegation of abuse or neglect following assignment to the demonstration compared with 44.2 percent of control group cases, a statistically insignificant difference. Of those cases with a subsequent allegation, 10 percent (22) of experimental group cases had a substantiated maltreatment report compared with 13 percent of control group cases (28), also an insignificant difference.

Enhancing Parents' Abilities and Strengthening Family and Child Well-Being

Of the four States with substance abuse waiver demonstrations, only Delaware and New Hampshire included measures of child and family well-being in their original evaluation plans. Delaware reported that it was unable to produce any meaningful data from its case intake and caregiver profile data to study these outcomes. New Hampshire has reported some initial well-being findings that point in a positive direction. For example, caregiver interviews conducted using the Child Behavior Checklist (CBCL) indicated greater declines in problem behaviors in seven of eight categories for children in the experimental group compared to children in the control group, with a particularly notable decrease in reports of aggressive child behaviors. Follow-up interviews with caregivers revealed additional positive well-being outcomes for adults with access to enhanced substance abuse services, with experimental group parents less likely to be on TANF at follow-up, more likely to be enrolled in an educational program, and more likely to be employed full-time than parents in the control group. While many of these findings lacked statistical significance, the pattern of somewhat improved outcomes across a number of domains suggests a positive trend for families receiving enhanced demonstration services.¹⁴

Summary of Outcome Findings

Findings to date from the States' evaluations illustrate the challenges of affecting positive changes in child welfare outcomes, including foster care placement prevention, placement stability, reunification, and overall permanency, among families with caregivers that have substance use disorders. However, some evidence from Illinois suggests that a substance abuse waiver may reduce the duration of foster care placements and lower the risk of maltreatment recurrence. In addition, recent findings from New Hampshire indicate that access to enhanced substance abuse services may have some positive effect on measures of parent and child well-being. Future evaluation findings from Illinois and New Hampshire will shed additional light on the effects of substance abuse waiver services on key child welfare outcomes. However, caution must be exercised in interpreting outcome findings across States given the substantial differences in their scope, size, service models, and target populations.

⁶“In-home” cases are those in which no children were in or entered foster care at any point during the demonstration. “Out-of-home” cases are those in which at least one child was in or entered foster care at the time of assignment to the demonstration or at some point following assignment. In all States, in-home cases include both those with substantiated and unsubstantiated maltreatment allegations.

⁷Maryland did not provide a breakout of in-home versus out-of-home cases.

⁸Michigan Alcoholism Screening Test.

⁹Estimates of the presence of mental health issues from New Hampshire and Illinois are derived from state child welfare/substance abuse databases. The figure for New Hampshire may underestimate the actual prevalence of mental illness among participants in that State's waiver demonstration. Based on a review of interview data from 200 subjects enrolled in its demonstration, New Hampshire's evaluators estimate that the incidence of depression/dysphoria

in its research sample is 40 percent as measured by the Center for Epidemiologic Studies Depression Scale (CES-D).

¹⁰Memorandum from the Illinois Department of Children and Family Services dated April 15, 2005.

¹¹E-mail correspondence from the Family Research Laboratory at the University of New Hampshire dated May 2, 2005.

¹²E-mail correspondence from the Family Research Laboratory at the University of New Hampshire dated May 11, 2005.

¹³Memorandum from Illinois Department of Children and Family Services dated April 15, 2005.

¹⁴Memorandum from the Family Research Laboratory at the University of New Hampshire dated April 15, 2005.

Lessons Learned from States' Experiences with Assisted Guardianship

Although the States' substance abuse waiver demonstrations differed from one other along several important dimensions, they experienced some common problems regarding case identification, participation in assessment, referrals, and service coordination. The demonstration States have not been alone in facing these problems; other substance abuse programs have experienced similar problems in recent years (U.S. Department of Health and Human Services, 1999). Although the approaches taken by demonstration States may be promising, these challenges underscore the continuing need to refine the policies and procedures for providing substance abuse services to caregivers involved in the child welfare system.

In reviewing the issues and findings presented in this synthesis paper, several important lessons emerge that serve as useful guidelines to other States considering substance abuse waiver demonstrations:

To maximize referral rates, States must examine their assumptions regarding the identification of substance use disorders and carefully define the target populations for their demonstrations.

All of the demonstrations operated under the assumption that significant proportions of their child welfare caseloads had caregivers with substance use disorders. Some States further assumed that child welfare workers could easily identify these cases and would readily refer them for enhanced substance abuse services once such services were made available. It appears, however, that the States overestimated the number of caregivers who would actually be referred for services. This was especially true in Delaware, Maryland, and New Hampshire, States in which child welfare staff were expected to identify caregivers with a substance problem soon after they entered the child welfare system. The referral process in these three States was further complicated by their inclusion of both in-home and out-of-home cases. Illinois' demonstration,

by contrast, only included caregivers with children placed in foster care and who had already been referred for substance abuse treatment by a licensed substance abuse specialist. Illinois' more focused definition of its target population made the referral process less problematic. Once initial case coordination problems had been resolved, referral rates in Illinois increased to levels similar to those anticipated at the start of its demonstration.

Child welfare staff need early and ongoing training regarding substance abuse waivers.

Although demonstration States routinely informed staff about the existence of new substance abuse waiver demonstrations, interviews and focus groups with frontline staff often revealed a lack of knowledge about the substance abuse services available through the waiver and the eligibility criteria for receipt of waiver services. In light of the significant problems with turnover in child welfare workers and substance abuse specialists noted in some States, it is also important to develop mechanisms to repeat training for new staff regarding waiver services and eligibility criteria.

Front-line child welfare staff need better training and tools to identify the presence, nature, and severity of substance use disorders.

Although child welfare workers may have a "hunch" about suspected alcohol or drug abuse, they may be reluctant to confront clients openly about a substance abuse problem and make a formal referral for treatment services. The challenge of identifying a probable substance use disorder consistently and accurately was most prevalent in Delaware and Maryland, States that relied on child welfare workers to make an initial determination of likely abuse or dependency and to refer caregivers to the waiver demonstration. This problem was less marked in Illinois, a State in which trained substance abuse specialists conduct formal assessments and make treatment recommendations for caregivers before they enroll in the demonstration.

Identifying the nature and severity of a substance use disorder often involves the administration of formal screening and assessment tools to assist in classifying and documenting drug and alcohol problems. Although New Hampshire and Illinois used licensed substance abuse specialists who followed formal protocols in identifying and assessing substance use disorders, Delaware and Maryland relied in part on child welfare workers with limited training and skill in conducting substance abuse screenings. Maryland in particular identified several instruments it planned to administer as part of a "global" assessment of caregiver and family needs, but it remains unclear to what extent waiver staff employed these tools or whether they received adequate training in their use and interpretation. This lack of training in the use of formal screening or assessment instruments may have exacerbated the problems experienced by staff in some States in identifying and documenting caregivers' substance use disorders. The administration of screening and assessment instruments by trained workers using standardized protocols would improve the systematic measurement of substance abuse and dependency among caregivers in the child welfare system and might increase workers' confidence in making appropriate service referrals.

Substance abuse treatment-child welfare collaborations are most successful when backed by strong managerial support.

Strong managerial support is needed to encourage workers to make referrals to substance abuse demonstrations and to adopt innovative practices in working with the families of substance-abusing caregivers. Delaware in particular noted the importance of supervisory support to facilitate referrals to its waiver program and to promote joint case planning by child welfare workers and substance abuse counselors.

Successful demonstrations require careful service coordination and consistent communication between child welfare staff and substance abuse professionals.

The experiences of all States highlight the need to coordinate service planning and case management activities between child welfare and substance abuse treatment personnel. The mere co-location of substance abuse professionals in CPS offices will not ensure that workers communicate about their cases. Successful service coordination requires the establishment of formal systems to share case information and to keep all staff informed about caregiver progress.

Successful substance abuse demonstrations have access to adequate and appropriate substance abuse treatment resources.

States based their substance abuse waivers in part on the assumption that adequate inpatient and outpatient treatment services would be available and accessible to clients. As Delaware's experience demonstrates, this assumption is not always valid. States need to coordinate with appropriate public and private treatment agencies to ensure access to adequate and suitable treatment services for caregivers with substance use disorders. Residential treatment facilities, particularly those that allow caregivers to reside with their children while they receive treatment, are of special importance.

States need reliable information tracking systems to promote the coordination of case management services and to improve the quality of evaluation data.

To support improved case management and service coordination, States must develop comprehensive and reliable tracking systems that give child welfare staff access to information on clients' treatment status, including treatment compliance and the results of drug tests. In addition, the establishment of effective information systems will strengthen the evaluation of substance abuse demonstrations by facilitating the collection of detailed process data associated with all stages of casework, from case referral through post-treatment follow-up. A broader range of information will increase States' understanding of what is required for the child welfare system to respond effectively to the needs of caregivers with substance use disorders.

To ensure cost neutrality in the context of a title IV-E waiver demonstration, States must carefully define the eligibility criteria of their target populations.

It is important to note that three of the four demonstration States (Delaware, Maryland and New Hampshire) made substance abuse treatment services available to all cases assessed as having a caregiver with a substance use disorder. These cases included those in which children remained at home while waiver services were provided. Due in part to the broad definition of their target populations, these States experienced greater difficulty in achieving cost neutrality; in other

words, the costs of serving families in their experimental groups were not offset by decreases in foster care spending adequate to ensure cost neutrality. In contrast, Illinois targeted its demonstration on caregivers whose children were already placed in foster care and focused on the goals of early reunification and preventing placement re-entry. By limiting the eligible population to foster care cases, States are more likely to avoid spending more title IV-E funds than they would have spent in the absence of the substance abuse waiver. Although in-home cases may indeed benefit from the enhanced services offered through the substance abuse waiver demonstrations and such services may produce cost savings in other areas over time, States may find it easier to realize title IV-E savings by targeting caregivers with children already in foster care.

At present, States implementing substance abuse waiver demonstrations have reported mixed success in improving substance abuse treatment and child welfare outcomes. The Maryland demonstration ended early due to a lack of program referrals, while both Delaware and New Hampshire have experienced difficulties with maintaining cost neutrality. Preliminary findings from Illinois suggest that its program may enhance access to treatment services, shorten the duration of foster care placements, and reduce the risk of maltreatment recurrence while realizing cost savings for the child welfare system. However, no State has been successful to date in promoting significantly greater rates of reunification or other forms of permanency. Other States considering the development of new interventions for families with caregivers experiencing substance use disorders are encouraged to study the lessons learned from these early demonstrations.

Next Steps

Final evaluation reports from New Hampshire and Illinois are forthcoming in July 2005 and December 2005, respectively. Results from these and future substance abuse waiver demonstrations will produce additional insights into the issues discussed in this synthesis paper and will further enhance our knowledge regarding the characteristics of successful substance abuse programs and their potential benefits for children, their parents, and the child welfare system.

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